BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RENE G. FLORES, Claimant, v. BOISE CASCADE, LLC, Employer, and OLD REPUBLIC INSURANCE COMPANY, Surety, Defendants.	)	**IC 2006-001912** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed: June 20, 2008

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted a hearing in Boise, Idaho, on August 28, 2007. Richard S. Owen of Nampa represented Claimant. Thomas P. Baskin of Boise represented Defendants. The parties submitted oral and documentary evidence. The record was held open for the taking of five post-hearing depositions, after which the parties submitted post-hearing briefs. The matter came under advisement on January 15, 2008, and is now ready for decision.

ISSUES

Subsequent to the hearing, Claimant withdrew two of the issues that had been identified at the hearing. The remaining issues to be decided are:

1. Whether Claimant has complied with the notice limitations set forth in Idaho Code §72-448;
2. Whether Claimant suffers from a compensable occupational disease;
3. Whether Claimant's condition is due in whole or in part to a pre-existing and/or subsequent injury or condition;
4. Whether and to what extent Claimant is entitled to the following benefits:
    a. Medical care;
    b. Temporary partial and/or temporary total disability benefits (TPD/TTD);
    c. Permanent partial impairment (PPI); and
    d. Disability in excess of impairment; and
5. Whether apportionment for a pre-existing or subsequent condition pursuant to Idaho Code § 72-406 is appropriate.

CONTENTIONS OF THE PARTIES

Claimant contends that he has established all of the necessary elements for a finding that he developed a repetitive motion injury to his low back in the autumn and early winter of 2005, and that he provided timely notice of his injury to Employer pursuant to Idaho Code § 72-448.[1] Claimant asserts that he is entitled to: Reasonably necessary medical care for his occupational injury, including surgery in April 2006; TTD benefits for the period of February 6, 2006 through August 28, 2006; PPI of 8% of the whole person resulting from the 2005 occupational injury and subsequent surgery; and substantial permanent partial disability in excess of his impairment.

Defendants argue that Claimant's occupational disease claim is not compensable under Idaho's workers' compensation laws. In particular, Defendants assert that Claimant failed to provide timely notice of his claim to Employer, that Claimant's low back complaints were the

[1] For ease of reference, the injury at issue in the instant case shall be identified as the 2006 injury.

result of an aggravation of a pre-existing condition and not compensable under the rule of *Nelson v. Ponsness Warren Idgas Enterprises*, 126 Idaho 129, 879 P.2d 592 (1994), and that Claimant has failed to establish all of the elements of an occupational disease claim. In the event that the Commission finds Claimant's injury to be compensable, Defendants concede a responsibility for a 9% PPI rating, but deny that Claimant sustained any disability in excess of his impairment as a result of the 2006 injury. Finally, in the event that Claimant's injury is compensable, Defendants urge that the Commission revisit its position regarding reimbursement of medical care costs that were paid by a third party as set out in *Sangster v. Potlatch Corp.*, 2004 IIC 0851. Defendants argue that since the decision in *Sangster*, the Commission has adopted rules governing medical fees, and that Defendants should not be required to reimburse more than would have been allowed had the claim been accepted.

Claimant replies that *Nelson* is not applicable on the facts of the case at bar because Claimant's 2006 injury was a new injury, not an aggravation of a pre-existing occupational injury, and because *Nelson* is limited to pre-existing injuries that pre-dated a claimant's employment with the employer from whom benefits are being sought. Finally, Claimant urges the Commission to apply the rule set out in *Sangster*, arguing that failure to do so could leave Claimant responsible to medical providers for the difference between invoiced amounts and allowed charges under the Commission's medical fee rules.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, Anita Flores, Ronan Reid, Gerald E. Green, Deena M. Brewer, Steven Henke, Tony Myslivy, Charlotte Plueckhahn, and Brian E. Johnson, taken at hearing;

2. Joint exhibits 1 through 31, admitted at hearing;

3. Post-hearing depositions of Nancy Jean Collins, Ph.D., taken September 19, 2007; Douglas Crum, taken October 25, 2007; Joseph Verska, M.D., taken September 18, 2007; R. Tyler Frizzell, M.D., taken October 16, 2007; and Christian Gussner, M.D., taken October 10, 2007.

Claimant's objection at p. 23 of Claimant's April 20, 2007 deposition is overruled. All objections made during the course of the post-hearing depositions of Douglas Crum, Dr. Frizzell, Dr. Gussner, and Dr. Collins are overruled. The Referee notes that all of these objections related to the form of the question, and did not raise substantive evidentiary issues. After having considered all the above evidence and the briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

1. Claimant was 60 years of age at the time of hearing and resided in Nampa with his wife, Anita.

2. Claimant attended school through fifth grade. He can speak, understand, read, and write basic English. His handwriting is poor and he relies on his wife to fill out most forms and handle paperwork. He has some ability to speak and understand Spanish. He has no additional schooling and never obtained a GED.

3. Claimant worked as a farm laborer, in a box-making factory, and for a modular home manufacturer before going to work in Employer's Nampa container plant in 1974.

4. At its Nampa plant, Employer fabricates boxes and cartons from corrugated paperboard. During the thirty-two years that Claimant worked for Employer, he worked on a number of different machines on the manufacturing floor. Claimant's work on two of the

machines is relevant to this proceeding—the "flexo" machine and the "slitter" machine.

5. Employer uses two types of flexo machine, but they function similarly. The machine takes a flat piece of cardboard and prints, slots, folds, and glues it, creating finished boxes of various sizes. Finished boxes arrive at the operator's station on a conveyor. The operator slides the boxes onto a retractable shelf with a pallet beneath it. The size of the pallet varies with the size of the box. Once a worker has placed a pallet-sized layer of boxes on the shelf, the shelf retracts, leaving the boxes on the pallet. The worker places another layer of boxes on the shelf and the shelf retracts, adding the second layer of boxes to the pallet. This process continues until the pallet is complete, at which time the pallet moves out of the machine and the process is repeated. The job of flexo operator does not require heavy lifting, but does require constant twisting, pushing, and reaching. The speed with which the flexo operator works is dependent upon the size of box and the speed of the conveyor.

6. The slitter takes large pieces of cardboard that would otherwise be waste, and cuts them into smaller pieces that are used in the manufacturing process. Operating the slitter is more physically demanding than working on the flexo machines, but the operator controls the pace of the work. The operator may cut very large pieces of cardboard with a skill saw or exacto-knife, lift the pieces onto the slitter, feed them through, then square the finished product and stack onto pallets. The slitter requires the operator to squat, stoop, or bend, kneel, reach above shoulder level, lift stock, cartons, or pallets up to sixty pounds, push or pull up to sixty pounds, and carry up to thirty-five pounds.

7. Claimant's work for Employer involved primarily physical labor and was in the medium-to-medium-heavy category of work as defined by the U.S. Department of Labor's Dictionary of Occupational Titles (DOT).

RECOMMENDATION - 5

2000 L4-5 HERNIATION AND SURGERY

8. In the spring or early summer of 2000, Claimant was working as the slitter operator (*See* Ex. 7, p. 3). He began experiencing intermittent back pain. The pain became more frequent and more persistent, and eventually moved into his right leg. In time, Claimant's symptoms led him to an immediate care clinic for evaluation and treatment, then to Dr. Verska for follow-up.

9. Claimant first saw Dr. Verska on July 7, 2000. Dr. Verska initially diagnosed a herniated disc at L4-5, and ordered an MRI. The MRI, done the same day, showed early degenerative changes at L1-2 and L2-3. There was disc desiccation at L4-5 with a central and right paramedian disc herniation that deformed the thecal sac and contacted the anterior margin of the right facet joint, likely compressing the crossing nerve root.

10. Dr. Verska performed a microdiscectomy at L4-5 on the right on July 24, 2000. Claimant made a normal recovery. Claimant was off work from July 11 until late October or early November 2000.

11. On October 17, 2000, Dr. Verska released Claimant to full work with a forty-pound lifting restriction. The release did not include a return-to-work date. Dr. Verska prepared a second work release on October 24. It released Claimant to full work effective October 25, 2000, with a "permanent" lifting restriction of forty pounds. Dr. Verska's records include notes of phone calls to Dr. Verska from Employer and from Claimant's wife regarding the October 24 work release. Testimony at hearing confirmed that Employer would not allow Claimant to return to work with the forty-pound lifting restriction. On November 3, 2000, Dr. Verska prepared a third work release returning Claimant to full work, without restrictions, effective November 6, 2000.

12. There is nothing in Dr. Verska's chart notes or intake forms that identify Claimant's lumbar complaints as work-related. An "Attending Physician's Statement" signed by Dr. Verska as part of Claimant's request for short-term disability benefits, specifically denies that Claimant's disability arose out of his employment. The *only* reference in the written record suggesting that the injury arose out of Claimant's work appears in a letter *to* Dr. Verska, dated July 26, 2000, prepared by Claimant's wife and signed by Claimant. In pertinent part, the letter states:

> . . . we were not sure how to answer some of the questions concerning whether or not this was an accident. Obviously, it was not. *However, as we discussed in your office, this has resulted from years of bending and lifting at work.*

Ex. 4, p. 34 (emphasis added).

13. At hearing, both Claimant and his wife testified that they believed that Claimant's work caused his 2000 herniation. There is no evidence Claimant notified Employer of a potential connection between Claimant's work and his back surgery. Claimant made no workers' compensation claim, and, with the exception of deductibles and co-pays, Claimant's health insurance paid for the treatment.

14. Upon and after his return to work in late 2000, Claimant continued to work for Employer, primarily as a slitter operator, without injury, accommodation, or complaint until sometime in the late summer or early fall of 2005.

OCCUPATIONAL INJURY CLAIM

15. In the late summer or early fall of 2005, Claimant began experiencing pain in his left leg with mild pain in his low back. At the time, Claimant was spending most of his work time (approximately 90%) at the slitter machine. At the outset, the leg and low back pain was intermittent, but by late November 2005, the leg pain was constant and severe, making it difficult

for Claimant to walk. Claimant self-treated with OTC anti-inflammatories but without much relief. Finally, in January 2006, Claimant's wife insisted that he seek medical treatment, and made him an appointment with Dr. Verska.

Medical Care

16. Claimant saw Dr. Verska on January 27, 2006. He described left leg pain and back pain, attributing eighty percent of his pain to his leg and twenty percent to his back. The chart note for that date records that Claimant's work required significant repetitive bending, lifting, and twisting. Claimant did not attribute his leg and back pain to a particular event, but rather to the repetitive nature of his work. On exam, Claimant exhibited positive responses to testing for lumbar radiculopathy. Based on his exam, and Claimant's report that his work required repetitive bending, lifting, and twisting, Dr. Verska ordered an MRI and released Claimant with lifting restrictions until the MRI was completed.

17. After leaving Dr. Verska's office, Claimant and his wife drove immediately to Employer's offices to report the work-related injury. Claimant's supervisors were upset that he had not reported the injury before seeing the doctor, and made him an appointment to see Ralph M. Sutherlin, D.O., at St. Luke's Occupational Health Services.

18. On January 31, 2006, Claimant entered the hospital with a bleeding ulcer, caused by Claimant's use of OTC anti-inflammatories for his leg and back pain. Claimant was also diagnosed with diabetes during his hospitalization. Claimant was treated for both conditions, and released several days later. Claimant never returned to work following his hospitalization. Following his diagnosis with diabetes, Claimant stopped driving because he was fearful that he would suffer a diabetic reaction while driving and possibly injure someone.

19. Claimant saw Dr. Sutherlin on February 6, 2006. Dr. Sutherlin diagnosed left

lumbar radiculopathy at L4-5. He prescribed muscle relaxants and pain medications, and restricted Claimant to modified work with no lifting more than ten pounds, and no repetitive stooping, bending, twisting, climbing ladders or stairs, and no prolonged vibration. No work was available within those restrictions. Dr. Sutherlin also ordered a lumbar MRI to rule out disc herniation versus degenerative disc disease.

20. An MRI was done on March 3, 2006, and Claimant saw Dr. Verska the same date with the MRI report. The MRI report detailed a left paracentral disc protrusion with subtle impingement of the left transversing nerve root. Based on the Claimant's history and the latest MRI, Dr. Verska opined:

> I think on a more probable than not basis his current symptoms and his disc herniation at L4-5 on the left are related to his work in that he has to do repetitive bending, lifting, and twisting primarily to the left. Although this gentleman does not have a specific traumatic episode, trip and fall, or a classic identifying injury I think this represents a repetitive injury to his low back.
>
> I do not think that this is preexisting, as his old disc herniation was on the right and his current disc herniation is on the left. If a patient is going to have a recurrent disc herniation it is typically on the same side of the old disc herniation and this represents an opposite side disc herniation.

Ex. 13, p. 13. Dr. Verska recommended a trial of epidural steroid injections (ESI), and took Claimant off work because there was no way for Claimant to work and avoid repetitive bending, lifting, and twisting.

21. Claimant returned to Dr. Verska after having two ESIs with minimal long-term relief. In the interim, Dr. Verska had reviewed the MRI images and observed a distal migrated free fragment of material on the left that was compressing the L5 nerve root. Dr. Verska recommended a microdiscectomy and Claimant chose to proceed with the surgical intervention.

22. Dr. Verska performed the microdiscectomy on April 19, 2006. There were no unforeseen complications and Verska's initial diagnosis was borne out during the surgery.

Claimant's recovery from the second microdiscectomy was neither as swift nor as complete as following his first surgery in 2000. On a follow-up visit to Dr. Verska on May 2, 2006, Claimant told Dr. Verska that he believed that his residual pain had been increasing in severity. Dr. Verska ordered another MRI to rule out residual or new herniation that could be causing the pain.

23. Claimant returned for follow up on May 9, 2006, having had the MRI earlier that day. Dr. Verska's interpretation of the MRI was that there might be scar tissue or disc tissue visible at L4-5, but Dr. Verska could not make a clear determination, and asked Claimant to return when the radiologist had had the opportunity to read the films.

24. Claimant returned on May 16, and Dr. Verska discussed the results of the MRI, which included a small residual or recurrent disc herniation at L4-5, not clearly impinging on the nerve. Dr. Verska did not believe that Claimant's remaining disc problem was surgical. Claimant told Dr. Verska that he could not return to work because of his pain, his diabetes, and the amount of lifting that his job required. Dr. Verska opined that a thirty-pound lifting restriction would be reasonable, and that there was probably some work Claimant could do within that limitation, but acknowledged that Claimant was probably not a good candidate for retraining. Dr. Verska referred Claimant to James H. Bates, a physiatrist, for impairment and disability ratings.

Impairment and Disability

25. Claimant saw Dr. Bates on May 23, 2006. After taking a patient history and performing an exam, Dr. Bates recommended a course of physical therapy. He also discussed the possibility of epidural steroids if therapeutic exercise did not provide relief. Claimant returned to Dr. Bates on June 6, 2006, reporting that the physical therapy had helped

considerably. Claimant remained concerned about his general recovery, activity level, protecting his back, returning to work, and what limitations would ultimately be imposed. Dr. Bates advised Claimant to continue the physical therapy and return to the clinic later that month.

26. On June 26, Claimant returned to see Dr. Bates. His leg pain had resolved. Dr. Bates continued the physical therapy. He advised Claimant that he should be at maximum medical improvement in about eight weeks. Dr. Bates also discussed permanent restrictions, telling Claimant that if all went well, he would have a permanent thirty-pound lifting restriction, no repetitive bending, stooping or lifting, no prolonged standing or sitting, and awareness and use of proper body mechanics with all moving and lifting.

27. On August 28, 2006, Dr. Bates released Claimant from care, declaring him to be medically stable. Claimant was advised to continue his home exercise program. Permanent restrictions were imposed:

- No lifts or carries in excess of 25 pounds;
- Occasional sitting, standing, walking; lifts and carries from 11 to 25 pounds; pushing or pulling with either arm; and reaching at or above shoulder level;
- Frequent lifts or carries up to ten pounds, bilateral grasping or power grasping, reaching below shoulder level; and
- Avoid unprotected heights and driving automotive equipment.

28. Claimant returned to Dr. Bates on April 18, 2007, for an impairment rating. Dr. Bates found Claimant had a permanent partial impairment of the whole person of 12%. Dr. Bates apportioned 5% of the total impairment to Claimant's 2000 injury with 7% attributable to the 2006 surgery.

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IME

29. Defendants sent Claimant to an independent medical evaluation (IME) by a panel of physicians consisting of Michael H. McClay, Ph.D., a clinical psychologist; Christian G. Gussner, M.D., a physiatrist; and R. Tyler Frizzell, M.D., a neurosurgeon.

Dr. McClay

30. Dr. McClay's report is dated May 9, 2007. Dr. McClay deferred to Drs. Gussner and Frizzell regarding Claimant's physical condition, but found that Claimant had a psychological diagnosis of "major depressive disorder," which was unrelated to and pre-existed his low back injury. Dr. McClay recommended that Claimant seek treatment for his depression, but that he should do so at his own expense.

Drs. Gussner and Frizzell

31. Following a review of the medical records, the panel took Claimant's history and both doctors performed an exam. Their diagnoses included:

> 1. Left L4-5 disk herniation, which on a more probable-than-not basis is related to the work injury of 11/27/05;[2]
>
> ***
>
> 3. Pre-existing right L4-5 disk herniation related to previous work injury in June 2000.

Ex. 26, p. 4. The doctors then answered a series of questions that had been posed by Defendants. Included in their responses were the following pertinent comments:

- The 2000 herniation and subsequent surgery predisposed the disc to future herniation;
- Claimant sustained a whole person impairment of 10% as a result of the 2000 injury and subsequent surgery;[3]

[2] It was on or around this date, the Thanksgiving holiday, that Claimant's pain became severe.

[3] The IME panel used the *AMA Guides to the Evaluation of Permanent Impairment*, 5th ed. (*AMA Guides*) for all impairment ratings discussed in this finding.

- Appropriate limitations following the 2000 injury and surgery would be medium duty with Claimant permitted to lift fifty pounds occasionally, and twenty-five pounds repetitively. Claimant should avoid repetitive bending, twisting, and torquing of his low back. He should change position often and avoid prolonged exposure to low-frequency vibration.
- Claimant sustained an additional 2% whole person impairment as a result of the second injury and subsequent surgery, making his diagnosis-related impairment 12%. In addition, Claimant was entitled to a rating of 8% for loss of range of motion. The panel used the *AMA Guides* combined values chart to calculate a 19% whole person impairment for Claimant, apportioning 10% of the impairment to Claimant's 2000 injury;
- Appropriate limitations following the 2006 surgery would be light-medium duty with Claimant permitted to lift thirty-five pounds occasionally, and twenty pounds repetitively. He should avoid repetitive bending, twisting, and torquing of the low back, change positions as needed, and avoid prolonged exposure to low-frequency vibration;
- Claimant's work as the slitter operator probably contributed the most to Claimant's second lumbar herniation, and the continuous lifting and twisting that this job required was not comparable to manual labor work in general;
- Claimant's bleeding duodenal ulcer was likely caused by his use of OTC anti-inflammatory medication starting in late November 2005.

VOCATIONAL EVIDENCE

32. Claimant retained Dr. Nancy Collins to prepare a vocational assessment and offer an opinion regarding his employability and to assess disability resulting from his occupational disease. Dr. Collins' report is dated June 25, 2007. Dr. Collins met with Claimant and reviewed

most, if not all, of the medical records that were extant at the time of her report. She also reviewed the depositions of Claimant and his wife. Her report presents an excellent understanding of Claimant's medical and work history.

33. Dr. Collins determined that Claimant's work for Employer constituted skilled labor, learned over many years on the job. She opined that given Claimant's age, his lack of formal education, and his inability to sit for long periods, that he was not a candidate for a formal retraining program.

34. Based on a review of the many positions that he held with Employer over his thirty-two year employment, Dr. Collins determined that Claimant's pre-injury work required medium-to-heavy physical exertion. Based on the permanent restrictions imposed after Claimant's 2006 surgery,[4] Dr. Collins found that Claimant was limited to light and light/medium work with additional limitations on bending, twisting, squatting, crawling, climbing, kneeling, and exposure to low-frequency vibration.

35. Using *LifeStep* computer software, Dr. Collins determined that before his injury, Claimant had transferrable skills for fifty-five job titles that exist in the national labor market. Post-injury, using the restrictions imposed by his physicians, Claimant had access to only two job titles. Claimant lacked the skills necessary to perform either of the jobs with his existing education and experience. Dr. Collins ran the LifeStep program a second time, this time including entry-level positions. Prior to his injury, Claimant had transferrable skills for 3156 job titles. After his injury, Claimant had transferrable skills for 1351 light and sedentary job titles. However, many of those identified job titles had minimum educational requirements. When

[4] The panel report recommended the following restrictions and limitations following the second discectomy: Permanent light-medium duty, including lifting a maximum of thirty-five pounds occasionally and twenty pounds repetitively; avoid repetitive bending, twisting, and torquing of the low back; change positions as needed; and avoid prolonged low-frequency vibration.

adjusted for Claimant's educational level, only 77 job titles remained.

36. Dr. Collins also analyzed Claimant's earning capacity before and after his injury. At the time of his injury, Claimant was earning approximately $15.00 per hour, together with a benefit package that included insurance, vacation, sick leave, retirement, and short-term disability. Dr. Collins noted that this was a high wage for someone without a high school diploma, but represented the skilled nature of Claimant's work. Following his injury, jobs available to Claimant were unskilled and paid from minimum wage ($5.15 per hour) to $7.00 per hour.

37. In addition to his physical and educational limitations, Claimant's age is a hindrance to employment. Because he had worked for a single employer most of his life, future employers will inquire why he left that job, which touches on issues of accommodating his need for frequent position changes. Dr. Collins conducted research in Claimant's local labor market seeking positions for which he was qualified and that were within his restrictions. The only positions she found that did not require at least a GED and fell within his physical limitations were jobs as a bus driver or a van driver. However, Dr. Collins noted that Claimant was no longer comfortable driving himself, so questioned whether he could realistically perform those driving jobs.

38. Dr. Collins ultimately opined that Claimant had disability in excess of his impairment of at least 80% based on his medical factors alone. She believed that there were entry level jobs that Claimant could perform, but that those positions were significantly limited by his need to change positions frequently.

Douglas N. Crum, C.D.M.S.

39. Defendants retained Douglas Crum to provide an analysis of Claimant's disability

in excess of his impairment. Mr. Crum's report is dated July 27, 2007. In reaching his conclusions, he reviewed medical records, the depositions of Claimant and his wife, personnel records, social security records, and Dr. Collins' report. He also met with Claimant and reviewed the video admitted into evidence as Ex. 23.

40. Mr. Crum ultimately opined that Claimant sustained very little, if any, disability in excess of his impairment as a result of the injury that precipitated this proceeding. Mr. Crum's analysis hinges on the IME panel's opinion that Claimant should have had restrictions following his first low back surgery. If Claimant had the restrictions recommended by the IME panel after the first surgery,[5] the difference in restrictions before and after his 2006 surgery was minimal.

DISCUSSION AND FURTHER FINDINGS

NOTICE

41. The requirements for notice and filing of occupational disease claims are set out at Idaho Code § 72-448, which provides in pertinent part:

> (1) Unless written notice of the manifestation of an occupational disease is given to the employer within sixty (60) days after its first manifestation, or to the industrial commission if the employer cannot be reasonably located within ninety (90) days after the first manifestation, and unless claim for worker's [sic] compensation benefits for an occupational disease is filed with the industrial commission within one (1) year after the first manifestation, all rights of the employee to worker's [sic] compensation due to the occupational disease shall be forever barred.

In the case at bar, Claimant asserts that he provided timely notice to Employer as required by the statute when he notified Employer on January 27, 2006—the day he was diagnosed by

[5] The panel report identified the following restrictions and limitations as appropriate following Claimant's 2000 surgery: Lift fifty pounds occasionally, lift twenty-five pounds repetitively; avoid repetitive bending, twisting, and torquing of the low back, change positions as needed, and avoid prolonged low frequency vibration.

Dr. Verska—that he had a low back injury caused by the repetitive bending, lifting, and twisting of his job. Defendants contend that Claimant did not comply with Idaho Code § 72-448 because Claimant knew when he first became symptomatic in late summer or early fall of 2005 that his symptoms were the result of a work-related back injury, so his January 27, 2006 notice to Employer was outside the sixty-day notice requirement.

Manifestation

42. Whether Claimant provided timely notice to Employer as required by Idaho Code § 72-448 depends upon the meaning of the term "manifestation" as used in the statute:

> "Manifestation" means the time when an employee knows that he has an occupational disease, or whenever a qualified physician shall inform the injured worker that he has an occupational disease.

Idaho Code § 72-102(19).

43. Defendants argue that the definition is written in the disjunctive—"when an employee knows . . . *or* whenever a qualified physician shall inform . . ." Use of the disjunctive "or" means that manifestation occurs when the first of either of the two events occurs. Since Claimant testified that he knew his condition was work related as soon as he began to experience symptoms in August or September 2005, that is when his occupational disease manifested.

44. In support of his position that his occupational disease manifested on January 27, 2006, the day it was diagnosed by Dr. Verska, Claimant points to the oft-cited language of *Boyd v. Potlach Corp.*, 117 Idaho 960, 161, 793 P.2d 192, 193 (1990):

> . . . for purposes of the notice and filing requirements of Idaho Code 72-448, an occupational disease is not manifest until its cause has been clearly identified by competent medical authority as related to the employee's work and that information has been communicated to the employee.

Subsequent to the *Boyd* decision, the legislature amended the law to include a statutory definition of "manifestation": "the time when an employee knows that he has an occupational disease, or

whenever a qualified physician shall inform the injured worker that he has an occupational disease." Idaho Code § 72-102(19). The Idaho Supreme Court revisited the issue of manifestation of an occupational disease in light of the new statutory definition in the more recent case of *Sundquist v. Precision Steel & Gypsum, Inc.*, 141 Idaho 450, 111 P.3d 135 (2005). In *Sundquist*, the Court addressed the nature of the knowledge requirement:

> This definition is subjective. The employee must know that he has an occupational disease or have been so informed by a qualified physician. In addition, the knowledge required is that he has an occupational disease, not that he has symptoms that are later diagnosed as being an occupational disease. Knowledge of symptoms is not synonymous with knowledge the symptoms are caused by an occupational disease.

Sundquist, 141 Idaho at 454, 111 P.3 at 139. The Referee finds that while Claimant might have suspected, or even known, that his low back symptoms were related to his work, he did not know that he had an occupational disease until he was diagnosed by Dr. Verska on January 27, 2006. The Commission has observed that a Claimant's belief about the "cause" of his complaints is as likely to be wrong as it is to be correct. "It is the experience of the Commission that Claimants often suspect or believe [a condition] to be work related when it is later shown to be unrelated." *Jackson v. JST Manufacturing*, 2005 I.I.C. 0160. Had Claimant sought workers' compensation benefits for his 2000 herniation, his belief that the herniation was caused by his work would not have been legally sufficient to establish his entitlement to benefits. Reciprocally, Claimant's belief that his low back pain in late 2005 and early 2006 was related to his work related is legally insufficient under *Sundquist* to trigger the notice requirements of Idaho Code § 72-448.

45. Defendants cited no contrary authority and made no attempt to distinguish the holding in *Boyd*, its predecessors or its progeny. The holding in *Boyd* is controlling on the issue of determining when Claimant's occupational disease became manifest, and the Referee finds that Claimant's occupational disease became manifest on January 27, 2006, when Dr. Verska

diagnosed the cause of Claimant's symptoms, related the cause to Claimant's work, and advised Claimant of the same. Claimant notified Employer the same day. Claimant's notice to Employer could not have been more timely.

COMPENSABLE OCCUPATIONAL DISEASE

46. Claimant, having cleared the hurdle of timely notice, must still prove that he actually has a compensable occupational disease as defined by Idaho Code § 72-102-(22)(a):

> "Occupational disease" means a disease due to the nature of an employment in which the hazards of such disease actually exist, are characteristic of, and peculiar to the trade, occupation, process, or employment . . .

Elements of an Occupational Disease Claim

47. The consensus of medical opinion is that the bending, lifting, and twisting activities of Claimant's work were implicated in causing his degenerative disc disease and disc herniation. Defendants do not dispute that Claimant's job required frequent bending, lifting and twisting, but rather assert that such activities are common to most manual labor jobs, and are not, therefore, "characteristic of and peculiar to" Claimant's employment. Defendants cite to *Bowman v. Twin Falls Construction Co., Inc.*, 99 Idaho 312, 323, 581 P.2d 770, 781 (1978), for the proposition that in order to meet the "peculiar to the occupation" requirement, the conditions of "employment must result in a hazard which distinguishes it in character from the general run of occupations." (Internal citations omitted).

48. The Referee finds that Claimant's injury was peculiar to his occupation and was distinguishable from the "general run" of manual labor occupations. Dr. Collins delineated the issue best in her deposition:

> Q: [By Mr. Owen] . . . Again, have you had a chance to talk to [Claimant] about the work that he did with respect to how much bending, twisting, and lifting he was required to do?
> A. Yes.

Q. And what did you learn?
A. Well, that the job really was on his feet all day, standing and walking and bending and twisting for most of the workday.
Q. Okay.
A. There was very little activity that didn't require bending, lifting or twisting.
Q. All right. In your experience categorizing these types of activities, how much of the work force does that kind of frequent or continuous bending, lifting, and twisting on the job?
A. Well, I think what's unique about some of these jobs is that it's so repetitive and it's all day long doing the same thing over and over and over. Most labor jobs change up activity more often than that.

Continuous bending—if you look at the DOT, less than 10 percent of the jobs in the DOT require continuous bending, and it's –it's significantly less than 10 percent.

If you adjust for it, it doesn't change much. So—and even frequent lifting is—less than 20 percent of the laborer jobs require frequent bending. So most jobs are designed more for the occasional bending requirement.
Q. How would you characterize what [Claimant] has told you about his job? Would it be occasional frequent or continuous lifting, bending, and twisting?
A. Well, it sounds like from both . . . [Claimant] and the panel docs and the way they describe it and Verska describes it is that it's continuous lifting, bending, and twisting.

Dr. Collins Depo., pp. 13-14.

49. While Claimant associated his leg and back pain with the time he spent working on the flexo machine, the vast majority of Claimant's work time was actually spent on the slitter machine. As demonstrated in the video of the various jobs, the work on the slitter required continuous bending, lifting, and twisting. It is the constant repetition of these three activities for long periods of time that set Claimant's work apart from the "general run" of labor jobs, and distinguish it from the cases cited by Defendants in their brief. The claimants in *Ogden v. Thompson,* 128 Idaho 87, 910 P.2d 759 (1996), *Ziebarth v. American Linen,* 200 I.I.C. 0009, and *Lewis v. Campbell's Quality Exteriors,* 2006 I.I.C. 0739, all had jobs that required heavy physical labor, but none of them shared the repetitive nature of Claimant's work. Manual labor jobs are often physically strenuous. If physical exertion alone were the touchstone, it is

tautological that all labor jobs would be among the "general run of occupations." It is not Claimant's level of exertion that distinguishes his work from the general run of labor jobs, it is the constant repetition.

Nelson v. Ponsness Warren Idgas Enterprises

50. Defendants further contend that even if Claimant proved all the elements of an occupational disease, his claim is barred by the rule in *Nelson v. Ponsness Warren Idgas Enterprises,* 126 Idaho 129, 879 P.2d 592 (1994). In *Nelson*, the Idaho Supreme Court held in relevant part that pre-existing conditions that are aggravated or accelerated by an occupational risk such as repetitive motion, are not compensable—there must be an "accident" as the term is defined in the workers' compensation statutes. Claimant's 2006 herniation was not the result of an industrial accident.

The *Nelson* doctrine, however, does not apply to all occupational disease cases:

> The *Nelson* doctrine does not apply to all cases where there is an occupational disease, only to those where the claimant's occupational disease preexisted employment with the employer from whom benefits are sought.

Sundquist, 141 Idaho at 453, 111 P.3d at 138, (internal citations omitted).[6] Claimant worked for Employer for 32 years. Even conceding that he had degenerative disc disease and a prior herniation as early as 2000, Defendants have failed to prove that either condition pre-existed Claimant's employment with Employer.

PRE-EXISTING INJURY OR CONDITION

51. It is undisputed that Claimant had a back injury and surgical repair in 2000. Defendants assert that the 2000 injury and surgery constitute a pre-existing condition that bears

[6] In *Sundquist*, the Claimant's pre-existing condition happened to be an occupational disease, thus the reference to a pre-existing occupational disease. In fact, the rule in *Nelson* is not limited to pre-existing occupational diseases, but to pre-existing conditions in general that are aggravated or accelerated by occupational activities.

on the compensability of the 2006 injury. The assertion that Claimant had a pre-existing condition is a thread that is woven into both the issue of notice and the compensability of the 2006 injury under *Nelson*. The thread was first evident in the depositions of Claimant and in the evidence adduced at trial regarding notice, where questioning raised the argument that Claimant's 2006 injury was just a continuation of the 2000 injury and thus his notice was six years too late. This argument was not followed up in Defendants' briefing. The thread resurfaces in the discussion of the applicability of *Nelson*. As discussed in the preceding section, *Nelson* is not applicable to the instant proceeding.

While a finding on the issue of a pre-existing condition has limited relevance to this decision, it is important that the issue be addressed for purposes of providing complete findings in the event of an appeal.

52. Defendants rely on the explanations and opinions of Drs. Gussner and Frizzell, in support of their position that Claimant had degenerative disc disease prior to his L4-5 herniation in 2000 and that the degenerative condition, together with the first herniation and surgical repair, led to the 2006 herniation. Claimant relies upon the opinion of his treating physician, Dr. Verska, in support of his position that the 2006 injury was a new injury and unrelated to his earlier herniation.

53. The Referee finds Dr. Verska's opinion more persuasive than the IME panel in this instance. Dr. Verska had the advantage of actually visualizing the extent and nature of both of Claimant's L4-5 disc herniations when opining that the two injuries were unrelated. Dr. Gussner is a physiatrist, not a surgeon. His knowledge of disc anatomy is academic and not practical. Dr. Frizzell is a surgeon, and has certainly seen his share of herniated discs, but he did not have the opportunity to see Claimant's injured disc except by way of imaging. In this case,

even the best imaging is a poor substitute for actual visualization of the injury.

54. Neither is the Referee persuaded by Dr. Gussner's opinion that Claimant's 2000 disc injury and repair contributed to the 2006 injury. As noted by Dr. Verska, a repeat herniation at the same location on the disc would not have been unexpected and would more likely be related to the earlier injury. Claimant's 2006 herniation was contralateral to the 2000 herniation, a fact that Dr. Verska particularly noted while explaining why the 2006 event was a new injury.

55. Finally, there was a lengthy period of time between the two events, during which time Claimant was symptom-free, without restriction, and performing the same work that he had performed in the many years that he was a laborer operating the various machines in Employer's container facility. Taken together, these facts lead the Referee to the conclusion that Claimant's 2006 injury was a new injury and unrelated to his 2000 injury.

MEDICAL CARE

56. An employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus, as may be required by the employee's physician or needed immediately after an injury or disability from an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer. Idaho Code § 72-432 (1). It is for the physician, not the Commission, to decide whether the treatment was required. The only review the Commission is entitled to make of the physician's decision is whether the treatment was reasonable. Sprague v. Caldwell Transportation, Inc., 116 Idaho 720, 779 P.2d 395 (1989).

57. Claimant is entitled to reimbursement for all reasonable medical costs incurred in treating his 2006 occupational injury, including his bleeding ulcer, in the amount of $42,590.91.

58. Defendants are self-insured for purposes of non-occupational group health coverage, and paid $23,079.54 of the invoiced amounts.

59. The Commission has consistently taken the position that employers should not benefit from the favorable contractual arrangements that medical insurers have negotiated with providers. *Sangster v. Potlatch Corp.*, 2004 I.I.C. 0851. When a claimant receives medical care paid for by non-industrial health insurance, and the claim is later determined to be compensable under workers' compensation provisions, the employer has been required to reimburse the "usual and customary charges," rather than the lesser amount paid by the claimant's health insurance. Defendants note that the Commission has held to the rule enunciated in *Sangster* when the Employer was self-insured for non-industrial health coverage, but has allowed the Employer a credit for the amounts actually paid in its capacity as a self-insured provider. See, *Rice v. Basic American Foods*, 2005 I.I.C. 0460.

Defendants assert that with regard to the balance owed on costs incurred for Claimant's care ($19,511.37), the Commission must revise its ruling in *Sangster* to bring it into conformity with the medical fee schedules that have been adopted by the Commission since the decision in *Sangster*. With the adoption of medical fee reimbursement rules which first became effective April 1, 2006, employers no longer pay for medical care in workers' compensation claims on the basis of "usual and customary charges," but instead pay according to the medical fee schedule.[7] Defendants assert that they should not be penalized for having denied a claim in good faith, and that Employer should only be required to pay what it would have been required to pay had the

[7] At the time that this decision is issued, hospitals are not subject to the medical fee schedule, being specifically exempted by the temporary rule that went into effect March 15, 2007. Between April 1, 2006, and March 15, 2007, hospital billings might have been paid on the "usual and customary charges" basis, or as a percentage of the amount billed depending upon the size of the hospital.

claim been accepted from the outset.

60. Claimant urges the Commission to adhere to the precedent set in *Sangster* and require Defendants to pay the full amount of the medical bills incurred by Claimant without set off, credit for amounts paid, or application of the medical fee rules to reduce the amount owing. In support of his position, Claimant argues that he is personally obligated to repay his health insurer in the event that his workers' compensation claim is found to be compensable. Further, Claimant is personally obligated to pay the medical providers for the services he received at the full invoiced amount. If Claimant fails to repay the subrogated interest of his health insurer or to pay the providers the amount for which he agreed to be responsible, then he is subject to suit in the state courts for repayment of the amounts. Providing a credit to Employer for amounts paid could deprive Claimant of the funds he needs to repay the subrogation interest of the health insurer. Application of the medical fee rules to the remaining $19,511.37 could deprive Claimant of the funds he needs to pay his contractual obligations to the medical providers. Since the Commission lacks jurisdiction over the contractual arrangements between Employer and Claimant for non-industrial health insurance, and similarly lacks jurisdiction over the contractual arrangements between Claimant and the non-industrial medical providers, Claimant asserts that the Commission should require Defendants to pay Claimant the full amount of the medical costs incurred. This leaves Claimant with both the responsibility, and the funds, to pay his personal contractual obligations to providers and satisfy the subrogation rights of his health insurer.

61. The Commission is persuaded by Claimant's argument. Defendants are obligated to compensate Claimant the full amount of $42,590.91 for medical care necessitated by his work injury. To do otherwise is inconsistent with both statutory and common-law principles of sure and certain relief for injured workers and their families and the oft-cited saw that the workers'

compensation statutes are to be liberally construed for the benefit of the injured worker.

TTDs

62. Pursuant to Idaho Code § 72-408, a claimant is entitled to income benefits for total and partial disability during a period of recovery. Defendants concede that if Claimant's claim is compensable, he is entitled to income benefits at the statutory rate for the period from February 6, 2006, through August 28, 2006.

IMPAIRMENT

63. "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or non-progressive at the time of the evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured worker's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and non-specialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

64. The parties are in agreement that Claimant is entitled to PPI benefits. Defendants' own IME panel rated Claimant's whole person impairment arising from the 2006 injury at 9%, which Defendants do not dispute. Claimant is entitled to PPI of 9% of the whole person for his 2006 injury.

DISABILITY

65. The definition of "disability" under the Idaho workers' compensation law is:

> . . . a decrease in wage-earning capacity due to injury or occupational disease, as such capacity is affected by the medical factor of physical impairment, and by pertinent nonmedical factors as provided in section 72-430, Idaho Code.

Idaho Code § 72-102 (10). A permanent disability results:

> when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected.

Idaho Code § 72-423. A rating of permanent disability is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors. Idaho Code § 72-425. Among the pertinent nonmedical factors are the following: the nature of the physical disablement; the cumulative effect of multiple injuries; the employee's occupation; the employee's age at the time of the accident; the employee's diminished ability to compete in the labor market within a reasonable geographic area; all the personal and economic circumstances of the employee; and other factors deemed relevant by the Commission. Idaho Code § 72-430.

66. There is a consensus between both vocational experts that Claimant has sustained significant disability in addition to his impairment. Both experts opined that Claimant's disability was somewhere between 70% to 80% of the whole person, inclusive of his impairment. The Referee finds that Claimant has sustained disability inclusive of his impairment of 80%. While this is the high end of the range identified by the vocational experts, the Referee believes that Claimant's age, lack of education, and poor reading, writing, and math skills justifies the higher percentage.

APPORTIONMENT PURSUANT TO IDAHO CODE § 72-406

67. Having found Claimant's low back injury to be compensable, apportionment of his disability becomes the single most contentious issue that remains to be decided. Defendants

assert that if Claimant's injury is compensable, the Commission must apportion Claimant's disability between the documented pre-existing low back condition and the claim that is the subject of this proceeding. Defendants attribute all of Claimant's disability to his 2000 low back injury. Claimant attributes all of his disability to the 2006 injury low back injury.

68. Since both vocational experts agreed on the amount of Claimant's disability, it is counter-intuitive that their opinions on apportioning the disability should be so divergent. The difference arises because Mr. Crum and Dr. Collins started with completely different assumptions.

As he explained in his deposition, Mr. Crum began with the following premise:

> In my analysis, I'm assuming that the panel restrictions for the 2000 injury are in place, and that Dr. Verska has now basically endorsed those.

Douglas Crum Depo., p. 37.

When Dr. Collins analyzed the issue of apportioning Claimant's disability, she began with the assumption that Claimant had no work restrictions as a result of his 2000 injury. The imposition of significant lifting and other limitations following the 2006 surgery represented a significant impact on Claimant's access to the labor market.

69. The Referee finds Mr. Crum's disability analysis novel, but without merit. To apportion disability based on hypothetical restrictions created in 2007 but imposed retroactively to the Claimant in 2000 requires a certain amount of *chutzpah*. In fact, from November 6, 2000, until he saw Dr. Verska on January 27, 2006, Claimant worked at his regular job, without any restrictions. Until the late summer of 2005, Claimant worked at his regular job, without any restrictions, and without any low back pain, problems, or complaints. The restrictions that "shoulda coulda woulda" been imposed on Claimant by the IME physicians following his first surgery are not relevant to this decision.

RECOMMENDATION - 28

70. The Referee accepts the vocational analysis prepared by Dr. Collins and apportions Claimant's disability in accordance with her report. While Claimant concededly had some impairment following his first injury, his ability to work and earn income was in no way compromised as a result of that injury. It was the imposition of significant limitations following his 2006 surgery that prevented him from returning to his time of injury job and severely reduced his access to the labor market and his earning capacity.

CONCLUSIONS OF LAW

1. Claimant complied with the notice limitations set forth in Idaho Code §72-448;
2. Claimant suffers from a compensable occupational disease;
3. Claimant's condition is not due in whole or in part to a pre-existing injury or condition;
4. Claimant is entitled to reimbursement for all reasonable medical costs incurred in treating his 2006 occupational injury, including his bleeding ulcer, in the amount of $42,590.91;
5. Claimant is entitled to TTD benefits at the statutory rate for the period from February 6, 2006, through August 28, 2006;
6. Claimant is entitled to whole person impairment of 9% for the 2006 injury;
7. Claimant has incurred disability of 80% of the whole person inclusive of his impairment;
8. Claimant's pre-existing impairment did not result in any disability, so apportionment of disability pursuant to Idaho Code § 72-406 is not appropriate—all of Claimant's disability is attributed to the 2006 injury.

RECOMMENDATION

Based upon the foregoing Findings of Fact, Conclusions of Law, and Recommendation, the Referee recommends that the Commission adopt such findings and conclusions as its own and issue an appropriate final order.

DATED this 28 day of May, 2008.

INDUSTRIAL COMMISSION

/s/_____
Rinda Just, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RENE G. FLORES, Claimant, v. BOISE CASCADE, LLC, Employer, and OLD REPUBLIC INSURANCE COMPANY, Surety, Defendants.	)	**IC 2006-001912** **ORDER** Filed: June 20, 2008

Pursuant to Idaho Code § 72-717, Referee Rinda Just submitted the record in the above-entitled matter, together with her proposed findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendation of the Referee. The Commission concurs with this recommendation. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant complied with the notice limitations set forth in Idaho Code §72-448;
2. Claimant suffers from a compensable occupational disease;
3. Claimant's condition is not due in whole or in part to a pre-existing injury or condition;

4. Claimant is entitled to reimbursement for all reasonable medical costs incurred in treating his 2006 occupational injury, including his bleeding ulcer, in the amount of $42,590.91;

5. Claimant is entitled to TTD benefits at the statutory rate for the period from February 6, 2006, through August 28, 2006;

6. Claimant is entitled to whole person impairment of 9% for the 2006 injury;

7. Claimant has incurred disability of 80% of the whole person inclusive of his impairment;

8. Claimant's pre-existing impairment did not result in any disability, so apportionment of disability pursuant to Idaho Code § 72-406 is not appropriate—all of Claimant's disability is attributed to the 2006 injury.

9. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this 20 day of June, 2008.

INDUSTRIAL COMMISSION

/s/_____
R.D. Maynard, Commissioner

/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

Concurring Opinion of Commissioner James F. Kile

Although I agree with all aspects of the Order issued by the Industrial Commission, I find it necessary to clarify a portion of our ruling. The subject of medical costs seems to be a continuing issue in situations in which the employer/surety denies the claim of an injured worker but is later determined to be responsible for the compensable injury.

Recently, several members of the defense bar have taken issue with rulings from the Commission on this subject. They have taken the stance that due to the implementation of the "new" IDAPA rule concerning the medical fee schedule, a ceiling on medical costs has now been established for contested cases. As reflected in our decision in this case, nothing has changed from prior circumstances or rulings of the Commission regarding reimbursement.

Prior to the "new" medical fee schedule, the Commission had an IDAPA rule that established medical costs at a reasonable level. This meant a "usual and customary" charge with an upper limit of the 90th percentile. IDAPA 17.02.08.031.02.d.f. These amounts were expressly related only to injury claims accepted by employers and sureties.

In many situations in the past, employers and sureties attempted to deny claims and then argue that their ultimate cost or exposure was the medical fee limit expressed in the "old" fee schedule. In some cases, these parties maintained that the reimbursement should be at the prevailing rates that they could obtain or contract from the "Blues" (Blue Shield, Blue Cross, Regence, etc.). The Commission consistently rejected this position. When a claim was denied and the injured worker had to personally contract for medical services for that injury and the injury was later determined to be compensable, the employer/surety was obligated as the responsible party to reimburse Claimant directly for such medical costs and services. The rate

within the medical fee schedule simply does not apply in contested cases as eloquently stated by the Commission Referee in this case. *See,* Edmonson and Sangster as previously cited.

The defense bar is now making the same argument believing the circumstances changed since the "new" medical fee schedule was implemented. The theories are the same as before. If a denied claim is ruled compensable by the Commission, the employer/surety argues, as in this case, that their ultimate responsibility is the medical fee schedule imposed by the current IDAPA rule. The Commission has once again rejected this position.

The medical fee schedule is designed for only accepted claims by the employer and surety. They can't have it both ways. The employer cannot deny a claim and fight over compensability, then argue that the reimbursement for the medical services contracted by the claimant can be no more than the regulated medical fee rate.

The fundamental answer is the same as before the revised medical fee schedule. Denial of a claim puts the employer/surety outside the regulated medical fee schedule. If a claimant seeks individual medical treatment, the worker is directly responsible for any medical expenses associated with such treatment. In other words, a claimant creates a separate contract of liability when contracting for medical services related to an industrial injury. The responsibility becomes personal, and only the worker is liable for those reasonable charges and expenses associated with the medical services of the industrial injury.

The rulings in Edmonson and Sangster are as applicable today under the revised medical fee schedule as they were appropriate under the former fee schedule. Nothing has changed the circumstances of reimbursement for a denied claim.

Both parties should realize their obligations and responsibilities in this context. The fundamental basis of the reimbursement system is the same. Responsibilities are the same. Case

law is still good law for this proposition. The Commission has not changed its position on this subject.

The workers' compensation system in Idaho is a fair and balanced system. The employer controls virtually all aspects of medical treatment and services for an injured worker when it accepts responsibility for the injury. However, once an employer denies the benefits of the system to an injured worker and that worker seeks medical treatment at their own discretion, the employer/surety has lost the guaranteed protections of the system in paying for medical services at the regulated medical fee rates. In this way, the system remains fair and balanced.

For these reasons, I also concur with the decision rendered by the Commission.

DATED this 20 day of June, 2008.

INDUSTRIAL COMMISSION

/s/_____
James F. Kile, Chairman

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 20 day of June, 2008, a true and correct copy of the foregoing **FINDINGS, CONCLUSIONS,** and **ORDER AND CONCURRING OPINION** was served by regular United States Mail upon each of the following persons:

RICHARD S OWEN
PO BOX 278
NAMPA ID 83653-0278

THOMAS P BASKIN
PO BOX 6756
BOISE ID 83707-6756

djb/cjh /s/_____